

**AUTHORIZATION TO OBTAIN MEDICAL INFORMATION  
REGARDING CLAIM FOR INJURED-ON-DUTY  
BENEFITS UNDER MASSACHUSETTS GENERAL  
LAWS CHAPTER 41, SECTION 100 & 111F**

I, \_\_\_\_\_ hereby authorize any licensed,  
(Print Name)  
physician, chiropractor, medical practitioner, nurse, hospital, clinic, and/or medical  
facility that has information as to the diagnosis, treatment and/or prognosis of

\_\_\_\_\_ that I sustained while working as a police  
(Specify Injury Sustained)  
officer of the City of Lowell on \_\_\_\_\_ to disclose those records and  
(Date of Injury)

information related to this injury only to the City of Lowell Law Department.

I understand that any such information will not be released by the City of Lowell Law  
Department to any other person or entity without the specific authorization of the  
undersigned. I understand that I shall be provided with a copy of this authorization upon  
request.

I agree that a photographic copy of this authorization, with a photographic copy of my  
signature, shall be as valid as the original.

This authorization shall expire upon a final determination by the City of Lowell Police  
Law Department as to whether I am entitled to benefits under Massachusetts General  
Laws Chapter 41, Section 111F for the injury sustained by me.

\_\_\_\_\_  
Name (Print)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Incident/Report #  
Revised 01/18//06/GAP

\_\_\_\_\_  
Date